Harold Derschowitz (x263)

From: numoh@umohlaw.com
Sent: Monday, July 14, 2008 4:44 PM
To: Harold Derschowitz (x263)
Subject: [FWD: RE: Mann v. Plus One, etc.]
Attachments: Mann, acceptance letter.pdf; Jordan Mann--Emails.pdf; Discovery letter Mann--Trump2.doc; Discovery letter Mann4.doc; Mann, tax authorizations.pdf; Mann, PIC Contract and name change.pdf

Uwem I. Umoh
255 Livingston Street,
4th Floor
Brooklyn, NY 11217
718.360.0527
800.516.5929 (Fax)

> -------- Original Message --------
> Subject: RE: Mann v. Plus One, etc.
> From: numoh@umohlaw.com
> Date: Mon, July 14, 2008 4:20 pm
> To: "Deborah MartinNorcross" <dmnorcross@martinnorcross.com>
> Cc: "Harold Derschowitz (x263)" <HDERSCHOWITZ@lskdnylaw.com>,
> chidieze@yahoo.com
>
> Counselors:
>
> Attached are my responses to your July 7, 2008 letters. The hard copies are in the mail.
>
> Uwem I. Umoh
> 255 Livingston Street,
> 4th Floor
> Brooklyn, NY 11217
> 718.360.0527

800.516.5929 (Fax)

-------- Original Message --------
Subject: Mann v. Plus One, etc.
From: "Deborah MartinNorcross" <dmnorcross@martinnorcross.com>
Date: Wed, July 09, 2008 9:40 am
To: "Harold Derschowitz (x263)" <HDERSCHOWITZ@lskdnylaw.com>, chidieze@yahoo.com, "numoh@umohlaw.com" <numoh@umohlaw.com>

Gentlemen:

Please see attached letter faxed to Judge Buchwald this morning regarding our request for an amendment to the scheduling order.

Deborah Martin Norcross
--
MartinNorcross LLC
60 Marion Road West
Princeton, NJ 08540
(609) 249-5860
(609) 945-3912 Fax
dmnorcross@martinnorcross.com

UWEM UMOH
ATTORNEY AT LAW
255 LIVINGSTON STREET, 4TH FLOOR,
BROOKLYN, N.Y. 11217

TEL: 718.360.0527 EMAIL: numoh@umohlaw.com FAX: 800.516.5929

BY EMAIL

July 11, 2008

Harold Derschowitz, Esq.
Lester Schwab Katz & Dwyer, LLP
120 Broadway
New York, NY 10271

Re: Jordan Mann v. Plus One Fitness et al.
07 CV 5691(RB)

Dear Harold Derschowitz:

This letter is written in response to your July, 7 and June 20, 2008 letters.

In regards to correspondence between the plaintiff and any defendant in this action, plaintiff refers defendants to documents Bates Stamped 189, 190 and 200. Also attached is a voicemail from Mike Murray, a Plus One employee that is not a defendant in this action. The voicemail was left on plaintiff's telephone following the incident with the Trump Tower resident Robert. It was left by Mr. Murray on June 8, 2006.

Attached are authorizations for New York State Department of Labor's records that pertain to plaintiff. Also attached are authorizations to Medicaid-- New York State Department of Health, plaintiff's taxes from 2006 to 2007 and authorizations for Retha Buck and Dr. Ann Boris's records of plaintiff's treatment. Plaintiff is unable to locate the addresses for Marlene Friedman or Crystal Huggins.

Regarding the interrogatories you served on plaintiff on May 30, 2008. First, your June 20, 2006 letter stating that plaintiff has chosen to ignore those interrogatories was premature, since plaintiff has 30 days under the federal rules in which to respond. Nevertheless, as indicated in my June 25, 2008 email, the interrogatories were served outside of the dates permitted in our scheduling order. They also far exceed the number allowed under the FRCP and we accordingly rejected the interrogatories.

The picture was taken on or about October 2004. Plaintiff is unsure of who took the picture.

Sincerely,

/s

NKEREUWEM UMOH

Cc:

DEBORAH MARTIN NORCROSS
MARTIN NORCROSS, LLC
110 WALL STREET, RCG SUITE 26th FLOOR
NEW YORK, NEW YORK 10004

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

Jordan Mann, Plaintiff, v. Plus One Fitness; Trump World Towers; "Robert" Doe; Jamie MacDonald; Does 1 – 10 inclusive, Defendant(s).	CIVIL ACTION NO. 07-CV-5691 (NRB/DF) BENEFITS RECORDS AUTHORIZATIONS

To: New York State Department of Labor
PO Box 15130
Albany, NY 12212

RE: JORDAN MANN
Case/File Reference No.:

You ate hereby authorized to release and furnish to the law firm of Lester, Schwab, Katz & Dwyer, 120 Broadway, New York, New York 10271, c/o Harold Derschowitz, attorneys of record for Defendants, complete copies of any and all benefit applications, records, doctors' reports, correspondence, notes, memoranda, invoices and all other documents of any nature that identify or in any way relate to the Workers' Compensation Unemployment Insurance Benefit/ Disability Benefits/Social Security/ Welfare and/or other Benefit claim that was filed by or on behalf of JORDAN MANN and any and all benefits paid to JORDAN MANN pursuant to such a benefit claim.

July 13, 2008

Jordan Mann
JORDAN MANN
Social Security No.: 147-78-1205

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
JORDAN "RHONDA" MANN	10/08/68	147-78-1209
Patient Address: 80 ST. NICHOLAS AVE, NEW YORK, NY 10026		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Medicaid, NYS Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237

8. Name and address of person(s) or category of person to whom this information will be sent:
Harold Derschowitz, Lester, Schwab, Katz & Dwyer, 120 Broadway, NY, NY 10271

9(a). Specific information to be released:

☑ Medical Record from (insert date) **6/01/2006** to (insert date) **Present**

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

JM **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**end of litigation**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Jordan Mann
Signature of patient or representative authorized by law.

Date: 7/13/08

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
JORDAN "RHONDA" MANN	10/08/68	147-78-1209
Patient Address: 80 ST. NICHOLAS AVE, NEW YORK, NY 10026		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Dr. Ann Boris, St. Luke's Roosevelt's Outpatient Clinic, 1000 Tenth Avenue, New York, NY 10019

8. Name and address of person(s) or category of person to whom this information will be sent:
Harold Derschowitz, Lester, Schwab, Katz & Dwyer, LLP, 120 Broadway, NY, NY 10271

9(a). Specific information to be released:

☑ Medical Record from (insert date) **June 1, 2006** to (insert date) **Present**

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

JM **Alcohol/Drug Treatment**

JM **Mental Health Information**

JM **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	end of legal matter
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Jordan Mann
Signature of patient or representative authorized by law.

Date: 7/13/08

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
JORDAN "RHONDA" MANN	10/08/68	147-78-1209
Patient Address: 80 ST. NICHOLAS AVE, NEW YORK, NY 10026		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Retha Buck, 1 University Place, New York, NY 10003 Tel. 212-982-1315

8. Name and address of person(s) or category of person to whom this information will be sent:
Harold Derschowitz, Lester, Schwab, Katz & Dwyer, LLP, 120 Broadway, NY, NY 10271

9(a). Specific information to be released:

☑ Medical Record from (insert date) **June 1, 2006** to (insert date) **Present**

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

JM **Alcohol/Drug Treatment**

JM **Mental Health Information**

JM **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	end of litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Jordan Mann

Signature of patient or representative authorized by law.

Date: 7/13/08

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

mb

ORIGINAL

FORM C

Rhonda Renee Mann
Your Name (first, middle, last)

259 5th St.
Street Address

Jersey City NJ 07302
Town, State, Zip Code

917 705 9660
Telephone Number

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION
Hudson COUNTY

DOCKET NUMBER: Hud-L-6430-06

FILED N/C 82885

NOV 0 3 2006

FRANCES L. ANTONIN, J.S.C.

FILED
DEC 13 2006
STATE TREASURER

In the Matter of the Application of
Rhonda Renee Mann
Your Name (first, middle, last)

To Assume the Name of
Jordan Sudan Mann
Name you wish to assume (first, middle, last)

CIVIL ACTION

FINAL JUDGMENT

Rhonda Renee Mann, having made application to this Court by duly verified complaint for a judgment authorizing (check one) __him ✓her to assume the name of Jordan Sudan Mann; and it appearing to the Court that all the provisions of N.J.S.A. 2A:52-1 to -4 and the Current N.J. Court Rules relating thereto have been complied with,

(your name, first, middle, last)
(name you wish to assume, first, middle, last)

IT IS on this 3rd day of Dec, 2006, **ORDERED AND ADJUDGED** that Rhonda Renee Mann, who was born October 8, 1968, and whose social security number is 147 78 1209, be and hereby is authorized to assume the name of Jordan Sudan Mann from and after Dec 2, 2006; and

(leave date blank for court to complete)
(your name, first, middle, last)
(month and day)
(year)
(your social security number)
(name you wish to assume, first, middle, last)
(Leave blank)

FORM C

DO NOT WRITE BELOW THIS LINE; THE COURT WILL COMPLETE.

IT IS FURTHER ORDERED that within twenty days hereof plaintiff shall cause a copy of this Final Judgment to be published once in Jersey Journal Newspaper and within forty-five days after entry of Judgment, plaintiff shall file proof of publication of this Final Judgment with the Deputy Clerk of the Superior Court (at the court address for the court in which you filed your verified complaint) and a certified copy of this Final Judgment with the Department of Treasury pursuant to the provisions of the Statute and Rules in such case made and provided: and

IT IS FURTHER ORDERED that the published version of the final judgement shall not include the plaintiff's social security number.

FRANCES L. ASTON, J.S.C. , J.S.C.

I, Joseph F. Davis, Deputy Clerk of the Superior Court of New Jersey, County of Hudson, do hereby certify that the foregoing is a true and correct copy of the original on file in my office.

Joseph F. Davis

Deputy Clerk of the Superior Court

Dated: 12/4/06

PACIFIC ISLANDS CLUB GUAM

JIIVANA SPA FOR WELL-BEING

at least $2,000,000 aggregate annual and $1,000,000 per incidence. Employer shall maintain insurance coverage for liability, fire and theft.

Term of Agreement

Either party may terminate this agreement, given reasonable cause, as provided below, or by giving 30 days written notice to the other party of the intention to terminate this Agreement:

a. Material violation of the provisions of this Agreement.
b. Any action by either party exposing the other to liability for property damage or personal injury.
c. Violation of ethical standards as defined by local, state and/or national associations and governing bodies.
d. Loss of licensure for services provided.
e. Employee fails to maintain the standard of service deemed appropriate by Employer.
f. Employee engages in any pattern or course of conduct on a continuing basis which adversely affects Employee's or Employer's ability to perform services.

This document constitutes the entire agreement between Employee and Employer and supersedes any and all prior written or verbal agreements. Amendments to this agreement must be in writing and signed by both parties. Should any part of this agreement be deemed unenforceable, the remainder of the agreement continues in effect. This agreement is governed by the laws of Guam. All unresolved disputes shall be settled by arbitration or mediation.

Signatures

IN WITNESS THEREINOF, the parties hereto have executed this Agreement on the dates noted by their respective signatures.

Fred R. Schuhmann
Human Resources Director

2/29/08
Date

Employee

2-25-08
Date

PACIFIC ISLANDS CLUB GUAM

JIIVANA SPA FOR WELL-BEING

Massage Therapist Employment Agreement

This agreement, dated 2nd Feb. 25, 2008, is by and between Guam & Guam, Inc., dba Pacific Islands Club Guam ("Employer"), with principal offices located at 210 Pale San Vitores Road, Tumon, Guam, and Jordan S. Mann ("Employee"):

EMPLOYMENT DATE:

Employment shall commence on the 25th day of Feb 2008, and shall continue for a period of one-year to the 25th day of Feb 2009.

Services, Equipment, and Supplies to be Provided by Employee

Employee agrees to provide massage therapy services within the scope of licensure. Employee is responsible for maintaining appropriate certification and licensure (including all costs thereof unless otherwise agreed). Employee agrees to dress in a style consistent with the Employer's image, including uniforms. Employee shall maintain client records in the manner prescribed by employer, and these records remain the property of the Employer.

When Employee isn't engaged in treatments, Employee shall assist with other spa duties as directed, including but not limited to:

a. Assisting other practitioners with clients or duties to ensure a harmonious flow of treatments and spa organizational function.
b. Assisting clients with aromatherapy blending, FIR sauna and Aqua Chi footbath.
c. Maintaining the organizational homeostasis of the spa.

Services, Equipment, and Supplies to be Provided by Employer

Employer shall provide the following: a safe, clean environment; a treatment room furnished with a massage table, chair, stool, hydrotherapy equipment and storage area, insurance billing, marketing and all necessary supplies and materials used in the performance of services (e.g., oils, lotions, linens and music).

PACIFIC ISLANDS CLUB GUAM

JIIVANA SPA FOR WELL-BEING

Other Provisions

a. Employee shall not solicit or provide services to Employer's clients for private practice or seek other employment while employed with Pacific Islands Club.

Fees, Terms of Payment, and Fringe Benefits

Employee shall be compensated at the base rate of $28,000 per annum, for a 40-hour work week, including 26 hours of hands-on massage therapy work and the remaining 14 hours spent on spa service duties. Employee shall be paid biweekly. Employee shall receive payment on all services performed regardless of the collection time. Employee may participate in any of the following: health insurance, personal leave time and 401K plan (see policy manual for details and eligibility requirements).

TRANSPORTATION

A. To Guam:

Employer will provide one-way economy class airfare from _____ to Guam for the Employee.

B. From Guam:

At the conclusion of this employment agreement, Employer will provide one-way economy class airfare from Guam to _____for the Employee.

Note: If Employee violates this agreement by leaving the employ of the Employer without written consent of the Employer, or the Employee is terminated for cause prior to the expiration of this agreement, the Employee will be required to reimburse Employer for all transportation costs. If Employer violates this agreement, the agreement is terminated and responsible for all transportation costs including one-way airfare home to NYC. jm

HOUSING:

The Employee will be provided shared housing on the premises in the sole discretion of the Employer. Employee will share housing with one other employee.

MEDICAL INSURANCE:

PACIFIC ISLANDS CLUB GUAM

JIIVANA SPA FOR WELL-BEING

The Employer will offer medical insurance coverage to the Employee in a group health plan selected by the Employer. If the Employee chooses to enroll, the Employee will be responsible for payment of fifty percent (50%) of the monthly premium cost of this group health plan. The Employee will be provided with a description of the plans offered by the Employer.

EMPLOYEE LEAVE:

Employee shall earn twelve (12) days of personal leave (to include vacation leave, sick leave, or other leave) after the completion of 1 year of employment under this Agreement. The Employee shall not be permitted to use employee leave until the completion of the first year of the employment term. This benefit shall only be applicable for therapists that complete a full year of employment and sign up for another term of employment.

IN-HOUSE BENEFITS:

a. Meals: The Employee will be provided with three (3) meals per day while employed by Employer at no charge to the Employee. Meals may be taken either in the Skylight Restaurant or the Employee Cafeteria.

b. Resort Privileges: The Employee shall be entitled to full usage of all PIC-Guam facilities.

c. Boutiki Discount: The Employee may purchase items at the Boutiki with a thirty percent (30%) discount. This is a benefit offered by the Boutiki. Should this arrangement change, the Employer will discontinue this practice.

Local, State, and Federal Taxes

Employer is responsible for paying all required local, federal withholding, social security and Medicare taxes.

Workers' Compensation

Employer provides Workers' Compensation Insurance at no cost to the employee.

Insurance

During the term of this agreement, Employee shall maintain a personal liability insurance policy with a reputable massage therapy organization as outlined in laws governing the United States of

Form **4506**
(Rev. January 2008)
Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.
▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T**, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
Jordan Mann	147-78-1209
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3
80 St. Nicholas Avenue, New York, NY 10026

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.
Harold Derschowitz, Lester, Schwab, Katz & Dwyer, 120 Broadway, NY, NY 10271

Caution: *DO NOT SIGN this form if a third party requires you to complete Form 4506, and lines 6 and 7 are blank.*

6 **Tax return requested.** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040 ☐
Note. If the copies must be certified for court or administrative proceedings, check here. ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

01 / 01 / 2006	01 / 01 / 2007	/ /	/ /
/ /	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 39.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here

Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a
Jordan Mann	7/13/08	(917) 646-9171
Title (if line 1a above is a corporation, partnership, estate, or trust)		
Spouse's signature	Date	